

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17

CERTIFICATE OF DEATH

Dr. McDonald
12351
Reg. Dist. No. 168

1. PLACE OF DEATH: Garrett
County

City or town Route 2 Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME George Dewey Baker

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Margaret Baker

7. Birth date of deceased (mo., day, yr.) October 5, 1860 6. (c) If alive, give age years

8. AGE: Years 85 Months 2 Days 23 If less than one day hrs. min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual occupation retired miner

11. Industry or business Fire clay mines

FATHER 12. Name Michael Baker

MOTHER 13. Birthplace Pennsylvania

14. Maiden name Carolina Bittner

15. Birthplace Pennsylvania

16. Informant Mrs. Leonard Klink

Address Route 2, Frostburg Md.

17. Burial Burial Date thereof Jan 2, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Johnson Cemetery

Location Frostburg, Md.

18. Funeral director J. J. Durst

Address Frostburg, Md.

19. Jan 2, 1946 Date rec'd by registrar

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)

State Maryland County Garrett

City or town Route 2, Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____ (If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number none

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 1945 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 19 to Dec 29 1945, and that I last saw him alive on Dec 29 1945.

Immediate cause of death Senility

Due to Arterio sclerosis

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, tell in the following:

Accident, suicide, or homicide _____ Date of _____

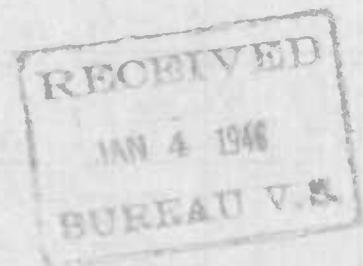
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE John J. Durst M. D. or other _____

Address Frostburg, Md. Date signed 12-29-45



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12352

Reg. Dist. No.

163

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 65 yrs
Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Thomas William Burke

4. Sex

5. Color or race

Male White Widow

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....
Mary Burke

7. Birth date of

deceased (mo., day, yr.)

Aug 5, 1898

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

97

8

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

not known

12. Name.....

13. Birthplace

not known

14. Maiden name.....

15. Birthplace

16. Informant

Bridget Marie Green

Address

Bloomington, Md.

17. Burial

Date thereof Dec 26, 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

St. Peter's Cemetery

Location

Westminster, Md.

18. Funeral director

Ellsworth & Son

Address

Westminster, Md.

19. Dec. 26 1945

Dorsey Patterson

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md County..... Garrett

City or town..... Bloomington (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 23 to Dec 23

and that I last saw him alive on Dec 23

Immediate cause of death

Blended Pregnancy

Due to

Pregnancy

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address..... Reedland, Md. Date signed



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12353

CERTIFICATE OF DEATH

Reg. Dist. No.

172

1. PLACE OF DEATH:

Garrett

County

Kitzmiller

City or town

(If outside city or town limits, write RURAL and give nearest town)

52 yrs

How long in above place of death?

Hospital, institution, or street address where death occurred:

Church St.

How long in hospital or institution?

3. (a) FULL NAME

Lawrence Mervin Cummings

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

Cummings

Virdella Catherine (DeWalt)

37

7. Birth date of

deceased (mo., day, yr.)

March 4, 1902

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

43

9

10

hrs.

min.

9. Birthplace

Bayard, Grant Co., W. Va.

(Town, county, and state)

Motorman

10. Usual occupation

Coal Mines

11. Industry or business

Franklin Cummings

12. Name

Tioga, Pa.

13. Birthplace

Lobertha Wolfe

14. Maiden name

Petersburg., W. Va.

15. Birthplace

18. Informant

Mrs. L. M. Cummings

Kitzmiller, Md.

Address

Dec. 17 1945

(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

17.

Cemetery or crematory

I. O. O. F. Cemetery

Location

Elk Garden, W. Va.

18. Funeral director

Otha F. Sharpless

Address

Blaine, W. Va.

19. (Date rec'd by registrar)

13/17 1945

(Date rec'd by registrar)

Lawrence Cummings

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Garrett

City or town

Kitzmiller

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Church Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number
232-09-1643

MEDICAL CERTIFICATION

Dec. 14

45

12:50 P.M.

20. DATE OF DEATH

Jan 1945, 10 Dec. 14 1945
and that last saw h.s.m alive on Dec. 14 1945

Immediate cause of death

Acute Myocarditis

DURATION

2 days

Due to

Bilateral Pulmonary

?

Due to

Tuberculosis

?

Other conditions

Blunt forces

?

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

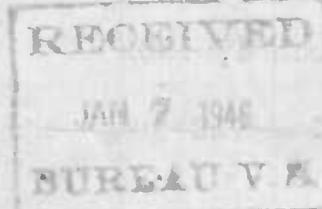
Ralph Colandella, M.D.

M. D. or other

Kitzmiller, Md.

Date signed

Dec. 15-45



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

Reg. Dist. No.

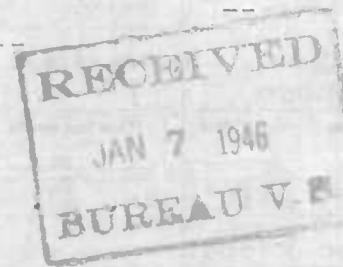
1. PLACE OF DEATH: **Garrett**
 County
 City or town **Oakland,**
 (If outside city or town limits, write RURAL and give nearest town)
5 years
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
4th St. St. Peters Rectory
 How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State. **Maryland** County **Garrett**.
 City or town **Oakland,**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **4th Street**
 (If rural, give LOCATION)
 2.(a) If veteran, name war. -----

3. (a) FULL NAME
Mary Agnes Dugan
 4. Sex **Female** 5. Color or race **White** 6.(a) Single, married, widowed, or divorced **Single**
 6.(b) Name of husband or wife. -----
 7. Birth date of deceased (mo., day, yr.) **unknown** 6.(c) If alive, give age **18 71** years
 8. AGE: **about 74** Years Months Days If less than one day
 hrs. min.
 9. Birthplace **probably Baltimore, Md.**
 (Town, county, and state)
 10. Usual occupation **House keeper**
 11. Industry or business **for others**
 FATHER 12. Name **Unknown**
 13. Birthplace **Unknown**
 MOTHER 14. Maiden name **Unknown**
 15. Birthplace **Rev. George E. Shipper**
 16. Informant **Rev. George E. Shipper**
 Address **Oakland, Md.**
 17. Burial Date thereof **Dec. 7, 1945**
 (Burial, cremation, or removal. Which?) **St. Marys Cemetery**
 Cemetery or crematory **Govans, Baltimore, Md.**
 Location **Nerbert & Leighton**
 18. Funeral director **Oakland, Maryland.**
 Address **Dec. 6 1945 Julia Ryan**
 (Date rec'd by registrar) **Local** Registrar

3. (b) Social Security Number -----

MEDICAL CERTIFICATION
 20. DATE OF DEATH **December 4** 1945 at **6 o'clock** m.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Unknown** after **death** and that I last saw her **alive** on **19**.
 Immediate cause of death **Cerebral Occlusion**
 Due to **Cerebrovascular**
 Due to **Arteriosclerosis**
 Other conditions **Unknown**
 (Include pregnancy within 8 months of death)
 Major findings of operations **Unknown**
 Date of op. **Unknown**
 Autopsy results **Unknown**
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide **Unknown** Date of **Unknown**
 Where did injury occur? **Unknown** (City or town) **Unknown** (County) **Unknown** (State)
 Injured at home, farm, industry, public place (where?) **Unknown**
 Means of injury **Unknown** Injured at work? **Unknown**
 23. SIGNATURES **J. J. Baumgartner M.D. & Anna Garrett**
 M. D. or other **Unknown**
 Address **Oakland, Md.** Date signed **12/5/45**



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

12355

CERTIFICATE OF DEATH

Reg. Dist. No. 162

1. PLACE OF DEATH: Garrett

County: Jennings
City or town: Jennings

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mrs Sidney Durst

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

F W Widowed

6.(b) Name of husband or wife: Louis Durst

7. Birth date of deceased (mo., day, yr.) February 13- 1864

8. AGE: Years Months Days If less than one day
81 10 11 hrs. min.9. Birthplace: R.D. 2 Grantsville Md
(Town, county, and state)

10. Usual occupation: House Work

11. Industry or business

12. Name: Samuel Custer
13. Birthplace: Not known14. Maiden name: Lydia Durst
15. Birthplace: Not known

16. Informant: Mrs Lee Broadwater

Address: Jennings Md

17. Burial Date thereof: 12-27-1945
(Burial, cremation, or removal. Which?)

Cemetery or crematory: New Germany

Location: R.D. 2 Grantsville Md

18. Funeral director: Mrs. Windberg

Address: Grantsville Md

19. Dec 26 1945 Ethel Broadwater
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Garrett

City or town: Jennings
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 25 1945 at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from
Influenza after 3rd week 10. and that I last saw her alive on 18.

Immediate cause of death

Coronary Occlusion

Due to Arteries clogged

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE: E. I. Baumgartner

M. D. or other

Address: Dallasland Date signed: 12-28-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1342

12356

166

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
Garrett
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
Oakland
27 yrs.
How long in above place of death?
Hospital, institution, or street address where death occurred:
Oak St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
Maryland
State.....
County.....
Oakland
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
Garrett
Street No.....
(If rural, give LOCATION)
Oak Street

3. (a) FULL NAME
Samuel Harold Jackson
4. Sex
Male
5. Color or race
White
6. (a) Single, married, widowed, or divorced
Married
6. (b) Name of husband or wife
Lettie Kelley Jackson
6. (c) If alive, give age years
67
7. Birth date of deceased (mo., day, yr.)
October 3, 1872
8. AGE: Years
73
Months
2
Days
27
If less than one day
hrs.
min.
9. Birthplace
Preston Co., W. Va.
(Town, county, and state)
10. Usual occupation
Retired Superintendent
11. Industry or business
Cumberland & Allegheny Gas Co.
12. Name
Philip Jackson
13. Birthplace
England

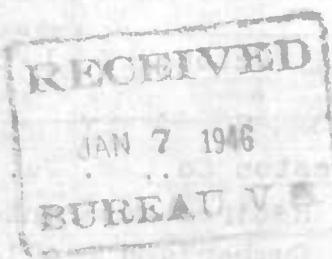
MOTHER FATHER
14. Maiden name
Sophia Heidelberg
15. Birthplace
Germany
16. Informant
Mrs. S. H. Jackson
Address
Oakland, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Jan. 1, 1946
Cemetery or crematory
Terra Alta, W. Va.

18. Funeral director
Herbert R. Keighan
Address
Oakland, Md.

19. (Date rec'd by registrar) Jan. 4, 1946
20. (Date of death) December 30, 1945
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
and that I last saw him alive on Dec. 29
22. MEDICAL CERTIFICATION
23. (a) If veteran, name war
3. (b) Social Security Number
216-07-7053

24. DATE OF DEATH
December 30, 1945, 3:30 A.M.
25. I CERTIFY that death occurred on the date above stated; that I attended deceased from
and that I last saw him alive on Dec. 29
26. MEDICAL CERTIFICATION
27. Immediate cause of death
Pulmonary Tuberculosis
28. DURATION
29. Due to
30. Due to
31. Other conditions
32. (Include pregnancy within 3 months of death)
33. Major findings of operations
34. Date of op.
35. Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
36. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
37. SIGNATURE
R. Baumer, M.D.
M. D. or other
38. Address
Oakland, Md.
39. Date signed
12/31/45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 460

CERTIFICATE OF DEATH

12357

166

Reg. Dist. No.

1. PLACE OF DEATH: Garrett
 County Crellin, Md.
 City or town Crellin, Md. (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 years
 Hospital, Institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Garrett
 City or town Crellin, Md. (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

3. (a) FULL NAME Asa Benjamine Johnson.
 4. Sex male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married.
 6. (b) Name of husband or wife Virgie O. Johnson.
 7. Birth date of deceased (mo., day, yr.) June 3d, 1871 6. (c) If alive, give age 66 years
 8. AGE: Years 74 Months 6 Days 25 If less than one day _____ hrs. _____ min.
 9. Birthplace Garrett County.
 (Town, county, and state) Laborer
 10. Usual occupation.....
 11. Industry or business Neil Johnson.
 MOTHER FATHER
 12. Name Maryland.
 13. Birthplace Catherine Everettts.
 MOTHER
 14. Maiden name Maryland.
 15. Birthplace Edward R. Johnson.
 16. Informant Tunnelton, W. Va.
 Address Burial Date thereof Dec. 30th/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Ashby Cemetery.
 Location Crellin, Md.
 18. Funeral director Ernest Bolden
 Address Oaklawn and
 19. Date rec'd by registrar Dec. 29, 1945 Julian A. Rawn
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number None.

MEDICAL CERTIFICATION A.M.

20. DATE OF DEATH December 28/45 19 at 12:40

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Na 1943 to Dee 1945 and that I last saw him alive on Ree 27 1945

Immediate cause of death Carcinoma of Colon DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

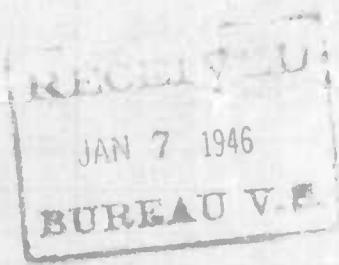
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Dr. Bannister and M. D. or other

Address Oaklawn and Date signed 12/28/45



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coverage
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

12358

CERTIFICATE OF DEATH

Reg. Dist. No. 172

1. PLACE OF DEATH **Garrett**
County **Shallmar**
City or town **Shallmar**
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? **28 yrs.**

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME **George Washington Lechliter**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, married, widowed, or divorced **Married**

6. (b) Name of husband or wife **Rebecca Catherine (Simmons) Lechliter** 60

7. Birth date of deceased (mo., day, yr.) **April 17, 1878**

8. AGE: **67** Years **8** Months **12** Days **If less than one day** hrs. min.

9. Birthplace **Patterson Creek, Mineral Co., W. Va.**
(Town, county, and state) **Miner**

10. Usual occupation **Coal mines**

11. Industry or business **John C. Lechliter**

12. Name **Cora Treter**

13. Birthplace **Cora Treter**

14. Maiden name **—**

15. Birthplace **—**

16. Informant **Mrs. George W. Lechliter**

Address **Shallmar, Md.**

Burial **Jan. 1, 1946**

(Burial, cremation, or removal. Which?) **I.O.O.F. Cemetery**

Cemetery or crematory **Eik Garden, W. Va.**

Location **—**

18. Funeral director **Otha F. Sharpless**

Address **Blaine, W. Va.**

19. Date rec'd by registrar **12-31 1945**

(Date rec'd by registrar) **Aug. 21, 1945**

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State **Maryland** County **Garrett**

City or town **Shallmar**
(If outside city or town limits, write RURAL and give nearest town)

Street No. **—**
(If rural, give LOCATION)

2. (a) If veteran, name war **no**

3. (b) Social Security Number **NONE**

MEDICAL CERTIFICATION

Dec. 29 45 8:35P

20. DATE OF DEATH **Jan. 1, 1946**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on **Dec. 29, 1945**

Immediate cause of death **Acute Appendicitis**

• Due to **Acute Appendicitis**

22. DURATION **2 days**

Due to **Acute Appendicitis**

23. DURATION **2 days**

Due to **Hypertension**

24. DURATION **2 days**

Other conditions **Left renal calculus**

Due to **Left renal calculus**

25. DURATION **2 days**

Other conditions **Acute appendicitis**

Due to **Acute appendicitis**

26. DURATION **2 days**

Other conditions **Left renal calculus**

Due to **Left renal calculus**

27. DURATION **2 days**

Other conditions **Acute appendicitis**

Due to **Acute appendicitis**

28. DURATION **2 days**

Other conditions **Left renal calculus**

Due to **Left renal calculus**

29. DURATION **2 days**

Other conditions **Acute appendicitis**

Due to **Acute appendicitis**

30. DURATION **2 days**

Other conditions **Left renal calculus**

Due to **Left renal calculus**

31. DURATION **2 days**

Other conditions **Acute appendicitis**

Due to **Acute appendicitis**

32. DURATION **2 days**

Other conditions **Left renal calculus**

Due to **Left renal calculus**

33. DURATION **2 days**

Other conditions **Acute appendicitis**

Due to **Acute appendicitis**

34. DURATION **2 days**

Other conditions **Left renal calculus**

Due to **Left renal calculus**

35. DURATION **2 days**

Other conditions **Acute appendicitis**

Due to **Acute appendicitis**

36. DURATION **2 days**

Other conditions **Left renal calculus**

Due to **Left renal calculus**

37. DURATION **2 days**

Other conditions **Acute appendicitis**

Due to **Acute appendicitis**

38. DURATION **2 days**

Other conditions **Left renal calculus**

Due to **Left renal calculus**

39. DURATION **2 days**

Other conditions **Acute appendicitis**

Due to **Acute appendicitis**

40. DURATION **2 days**

Other conditions **Left renal calculus**

Due to **Left renal calculus**

41. DURATION **2 days**

Other conditions **Acute appendicitis**

Due to **Acute appendicitis**

42. DURATION **2 days**

Other conditions **Left renal calculus**

Due to **Left renal calculus**

43. DURATION **2 days**

Other conditions **Acute appendicitis**

Due to **Acute appendicitis**

44. DURATION **2 days**

Other conditions **Left renal calculus**

Due to **Left renal calculus**

45. DURATION **2 days**

Other conditions **Acute appendicitis**

Due to **Acute appendicitis**

46. DURATION **2 days**

Other conditions **Left renal calculus**

Due to **Left renal calculus**

47. DURATION **2 days**

Other conditions **Acute appendicitis**

Due to **Acute appendicitis**

48. DURATION **2 days**

Other conditions **Left renal calculus**

Due to **Left renal calculus**

49. DURATION **2 days**

Other conditions **Acute appendicitis**

Due to **Acute appendicitis**

50. DURATION **2 days**

Other conditions **Left renal calculus**

Due to **Left renal calculus**

51. DURATION **2 days**

Other conditions **Acute appendicitis**

Due to **Acute appendicitis**

52. DURATION **2 days**

Other conditions **Left renal calculus**

Due to **Left renal calculus**

53. DURATION **2 days**

Other conditions **Acute appendicitis**

Due to **Acute appendicitis**

54. DURATION **2 days**

Other conditions **Left renal calculus**

Due to **Left renal calculus**

55. DURATION **2 days**

Other conditions **Acute appendicitis**

Due to **Acute appendicitis**

56. DURATION **2 days**

Other conditions **Left renal calculus**

Due to **Left renal calculus**

57. DURATION **2 days**

Other conditions **Acute appendicitis**

Due to **Acute appendicitis**

58. DURATION **2 days**

Other conditions **Left renal calculus**

Due to **Left renal calculus**

59. DURATION **2 days**

Other conditions **Acute appendicitis**

Due to **Acute appendicitis**

60. DURATION **2 days**

Other conditions **Left renal calculus**

Due to **Left renal calculus**

61. DURATION **2 days**

Other conditions **Acute appendicitis**

Due to **Acute appendicitis**

62. DURATION **2 days**

Other conditions **Left renal calculus**

Due to **Left renal calculus**

63. DURATION **2 days**

Other conditions **Acute appendicitis**

Due to **Acute appendicitis**

64. DURATION **2 days**

Other conditions **Left renal calculus**

Due to **Left renal calculus**

65. DURATION **2 days**

Other conditions **Acute appendicitis**

Due to **Acute appendicitis**

66. DURATION **2 days**

Other conditions **Left renal calculus**

Due to **Left renal calculus**

67. DURATION **2 days**

Other conditions **Acute appendicitis**

Due to **Acute appendicitis**

68. DURATION **2 days**

Other conditions **Left renal calculus**

Due to **Left renal calculus**

69. DURATION **2 days**

Other conditions **Acute appendicitis**

Due to **Acute appendicitis**

70. DURATION **2 days**

Other conditions **Left renal calculus**

Due to **Left renal calculus**

71. DURATION **2 days**

Other conditions **Acute appendicitis**

Due to **Acute appendicitis**

72. DURATION **2 days**

Other conditions **Left renal calculus**

Due to **Left renal calculus**

73. DURATION **2 days**

Other conditions **Acute appendicitis**

Due to **Acute appendicitis**

74. DURATION **2 days**

Other conditions **Left renal calculus**

Due to **Left renal calculus**

75. DURATION **2 days**

Other conditions **Acute appendicitis**

Due to **Acute appendicitis**

76. DURATION **2 days**

Other conditions **Left renal calculus**

Due to **Left renal calculus**

77. DURATION **2 days**

Other conditions **Acute appendicitis**

Due to **Acute appendicitis**

78. DURATION **2 days**

Other conditions **Left renal calculus**

Due to **Left renal calculus**

79. DURATION **2 days**

Other conditions **Acute appendicitis**

Due to **Acute appendicitis**

80. DURATION **2 days**

Other conditions **Left renal calculus**

Due to **Left renal calculus**

81. DURATION **2 days**

Other conditions **Acute appendicitis**

Due to **Acute appendicitis**

82. DURATION **2 days**

Other conditions **Left renal calculus**

Due to **Left renal calculus**

83. DURATION **2 days**

Other conditions **Acute appendicitis**

Due to **Acute appendicitis**

84. DURATION **2 days**

Other conditions **Left renal calculus**

Due to **Left renal calculus**

85. DURATION **2 days**

Other conditions **Acute appendicitis**

Due to **Acute appendicitis**

86. DURATION **2 days**

Other conditions **Left renal calculus**

Due to **Left renal calculus**

87. DURATION **2 days**

Other conditions **Acute appendicitis**

Due to **Acute appendicitis**

88. DURATION **2 days**

Other conditions **Left renal calculus**

Due to **Left renal calculus**

89. DURATION **2 days**

Other conditions **Acute appendicitis**

Due to **Acute appendicitis**

90. DURATION **2 days**

Other conditions **Left renal calculus**

Due to **Left renal calculus**

91. DURATION **2 days**

Other conditions **Acute appendicitis**

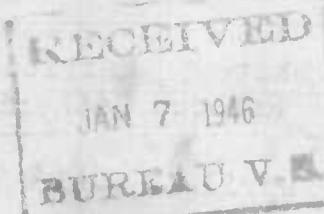
Due to **Acute appendicitis**

92. DURATION **2 days**

Other conditions **Left renal calculus**

Due to **Left renal calculus**

93. DURATION **2 days</b**



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2A

12359

CERTIFICATE OF DEATH

Reg. Dist. No. 162

1. PLACE OF DEATH:

County Garrett

City or town Rural Near Grantsville

(If outside city or town limits, write RURAL and give nearest town)

27 Years

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Anthony Cresent Lewis

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

M W Married

6.(b) Name of husband or wife Sara Lewis

7. Birth date of deceased (mo., day, yr.) November 29 - 1876

8. AGE: Years Months Days If less than one day
69 - 21 hrs. min.9. Birthplace New York City, New York
(Town, county, and state)

10. Usual occupation Coal Miner

11. Industry or business

12. Name Newton Lewis

13. Birthplace Not Known

14. Maiden name Not Known

15. Birthplace Not Known

16. Informant Mrs. Sara Lewis

Address R.D.2 Grantsville Md

17. Burial

(Burial, cremation, or removal. Which?) Date thereof Dec. 23-1945

(month) (day) (year)

Cemetery or crematory Grantsville

Location Grantsville Md

18. Funeral director Max Winterberg

Address Grantsville Md

Dec 22 1945 (Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Garrett

City or town Rural Near Grantsville Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

213-18-2602

MEDICAL CERTIFICATION

2D. DATE OF DEATH December 20 1945 at 4 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 1 1945 to Dec 20 1945 and I last saw him alive on Dec 19 1945

Immediate cause of death

Cerebral Hemorrhage today

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

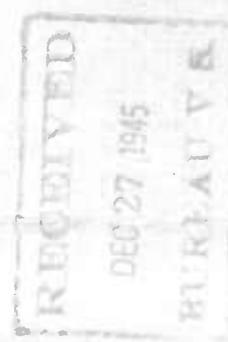
Injured at work?

23. SIGNATURE

M. D. or other

Address

N. R. Davis M.D. Grantsville Md Date signed Dec 22 1945



MARGIN RESERVED FOR BINDING

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

12360

1. PLACE OF DEATH

County. Garrett

Village or City. Kempton

Registration Dist. No.

167

St.

Ward

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME. James Issac McMANUS

(a) Residence: No.

(Usual place of abode)

No.

St.

Ward.

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Bertie May Ashfield

6. DATE OF BIRTH (month, day, and year) June 14, 1871

7. AGE	Years	Months	Days	If LESS than 1 day, _____ hrs. or _____ min.
	74	5	20	

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Retired Miner
9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Franklin
(State or country) Allegheny Co., Md.

13. NAME Joseph Mc Manus

14. BIRTHPLACE (city or town) Unknown
(State or country)

15. MAIDEN NAME Unknown Smith

16. BIRTHPLACE (city or town) Unknown
(State or country)

17. INFORMANT Bay Mc Manus
(Address) Kempton, West Va.

18. BURIAL, CREMATION, OR REMOVAL
Place Bayard, W. Va. Date Dec. 7, 1945

19. UNDERTAKER J. D. Duncan
(Address) Thomas, West Va.

20. FILED 12/19/1945 - Elmer C. Shaffer
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

December

4

1934

(Month)

(Day)

(Year)

22. I HEREBY CERTIFY. That I attended deceased from

Sept. 24, 1945, to Dec. 4, 1945.

I last saw him alive on Dec. 4, 1945, death is said to have occurred on the date stated above, at 8:00 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Myocarditis Endocarditis

Date of onset

Other Contributory Causes of importance

Arteriosclerosis and coronary occlusion

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____

Specify city or town, county and State

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE

Manner of Injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify _____

(Signed)

C. P. Burke M. D.
(Address) Thomas, W. Va.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:

Gallstones	May 1, 1923
------------	-------------

Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy	1 week ago
Run over by street car	DEC 10 1927 1 week ago
Peritonitis	3 days ago

Other contributory causes of importance:

Gastroenteritis	1 year
-----------------	--------

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Reg. Dist. No.

172

1. PLACE OF DEATH

Garrett

County

Kitzmiller

City or town

(If outside city or town limits, write RURAL and give nearest town)

12 yrs.

How long in above place of death?

Hospital, institution, or street address where death occurred:

Spring St.

How long in hospital or institution?

3. (a) FULL NAME

Stella Frances McRobie

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

Joseph Francis McRobie

5. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Aug. 26, 1865

6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day

80

3

16

hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

Own Home

MOTHER

12. Name

Abraham McRobie

13. Birthplace

Nancy Catherine Friend

MOTHER

14. Maiden name

Mrs. Stella Rohrbaugh

15. Birthplace

Kitzmiller, Md.

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Dec. 14, 1945

(month) (day) (year)

Cemetery or crematory I.O.O.F. Cemetery

ElkGarden, W.Va.

Location

18. Funeral director

Otha F. Sharpless

Address

Blaine, W.Va.

19. 12/14 45 Ambulance

(Date rec'd by registrar)

19. 45 Ambulance

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Garrett

City or town Kitzmiller

(If outside city or town limits, write RURAL and give nearest town)

Street No. Spring Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 45 10:10A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.40 to 10:10A.M. 19.40 and last saw h. alive on

Immediate cause of death

Cerebral Hemorrhage

Due to

Atrial Fibrillation

DURATION

10 yrs?

Due to

Hypertension

10 yrs

Other conditions

Senility

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

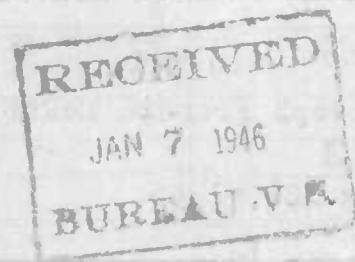
Injured at work?

23. SIGNATURE

Ralph Calandella M.D.

M. D. or other

Address Cityville, Md. Date signed 12-17-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

12362966

CERTIFICATE OF DEATH

Reg. Dist. No. ★

1. PLACE OF DEATH:

County Garrett

City or town Oakland, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Life time

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Harold Esmond Miller.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married.

6. (b) Name of husband or wife

Etta Cogley Miller.

7. Birth date of deceased (mo., day, yr.)

June 19th 1877

6. (c) If alive, give age

73

years

8. AGE:

Years

Months

Days

If less than one day

68

5

20

hrs. min.

9. Birthplace

West Virginia.

(Town, county, and state)

10. Usual occupation

Stone Mason

11. Industry or business

James G. Miller.

FATHER

Name

West Virginia.

MOTHER

Name

Melissa L. Hewitt.

Birthplace

West Virginia.

16. Informant

Mrs. Etta Miller.

Address

Oakland, Md.

17. Burial

Date thereof December 14/45

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Oakland Cemetery.

Location

Oakland, Md.

18. Funeral director

George D. Biddle

Address

Oakland, Md.

19. Date rec'd by registrar

Dec. 13 1945

Falm Royal

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborns infants give residence of mother)

State Maryland County Garrett

City or town Oakland, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

220-10-2839

P.M.

MEDICAL CERTIFICATION

M

20. DATE OF DEATH December 11th 1945 at 5:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 28, 1945, to December 10, 1945,

and that I last saw him alive on

19

Immediate cause of death

coronary occlusion

DURATION

Due to hypertension, benign -

19

Due to arteriosclerosis.

19

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Audrey E. Hance, M.D.

M. D. or other

101 Third Street

Oakland, Md.

Date signed 12/13/45

LETTER TO THE SECRETARY OF STATE, GENEVIEVE

RECEIVED TO STANISLAW



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1193

12363

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH:

Garrett
County
Swanton Rural

City or town
(If outside city or town limits, write RURAL and give nearest town)
10 mo.

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Gary Williams Paugh

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) February 20, 1945

8. AGE:

Years

Months

Days

If less than one day

--

10

11

hrs.

min.

9. Birthplace: Garrett Co., Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

Charles L. Paugh

12. Name: Charles L. Paugh

13. Birthplace: Bloomington; Garrett Co., Md

14. Maiden name: Bessie Virginia Kitzmiller

15. Birthplace: Harrison, W. Va.

16. Informant: Charles L. Paugh

Address: Vindex, Md.

17. Burial

Date thereof: Jan. 2, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Mt. Zion Cemetery

Location: 6 Mi. So. Swanton, Md.

18. Funeral director:

Herbert C. Leighlow

Address: Oakland, Md.

19. (Date rec'd by registrar)

Jan. 2, 1946 Julian Rowan

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland County Garrett

City or town: Rural Swanton

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1 Mi. East Swanton

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

December 31, 1945 3:35 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12-24-45

19

12-31-45

19

and that I last saw him alive on

1m

12-24-45

19

Immediate cause of death: Acute Bronchitis
and DiarrheaDURATION
1 WEEK

Due to:

Due to:

Other conditions:

(Include pregnancy within 8 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Edward L. Bokslawsky

M. D. or other

Address: Oakland, Maryland

Date signed: 1-1-46

STATION 90 - TENNESSEE STATE CHAMBER

RECEIVED

JAN 28 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12

CERTIFICATE OF DEATH

Reg. Dist. No. 12364/6

1. PLACE OF DEATH

Garrett

County

Mt. Lake Park

(If outside city or town limits, write RURAL and give nearest town)

20 yrs.

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Susie Lovina Roy

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female

White

Married

6.(b) Name of husband or wife

James Richard Roy

77

years

7. Birth date of deceased (mo., day, yr.)

September 26, 1878

8. AGE:

Years

Months

Days

If less than one day

67

2

14

hrs.

min.

9. Birthplace

(Town, county, and state)

House Wife

10. Usual occupation

Own Home

11. Industry or business

George W. Fulmer

12. Name

Ohio.

13. Birthplace

Jennie Green

14. Maiden name

Mineral Co., W. Va.

15. Birthplace

Mrs. Richard Roy Jr.

16. Informant

Mt. Lake Park, Md.

Address

17. Burial

Date thereof Dec. 13, 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Pleasant Valley Cemetery

Cemetery or crematory

2 Mi So. Oakland, Md.

Location

18. Funeral director

Neherl E. Leighton

Address

19. Date rec'd by registrar

19

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

County

Garrett

City or town

Mt. Lake Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 10, 1945, 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.

to

and that I last saw h. alive on

19.

Immediate cause of death

Coronary Declerosis

DURATION

Due to Arterio sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

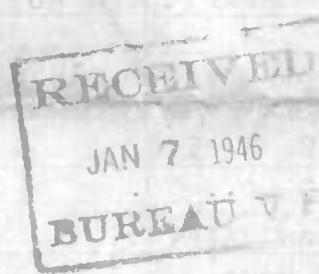
23. SIGNATURE

L. E. Flaneur, M.D.

M. D. or other

Address Oakland, Md. Date signed 12/13/45

RECEIVED THIS TWENTY-THREE DAY OF JANUARY
NINETEEN FORTY-SIX



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12365
Reg. Dist. No. 62

1. PLACE OF DEATH:

County..... Garrett Co.
City or town..... Grantsville

(If outside city or town limits, write RURAL and give nearest town)

16 Days

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Harriet Jane Stahl

4. Sex

F	W
---	---

 5. Color or race

Widowed

 6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife..... George Stahl

7. Birth date of deceased (mo., day, yr.)

August 31		1864	
-----------	--	------	--

 6.(c) If alive, give age..... years8. AGE:

Years	Months	Days	If less than one day
81	3	9	hrs. min.

9. Birthplace..... Jennings Md Garrett Co
(Town, county, and state)

10. Usual occupation..... House Work

11. Industry or business

12. Name..... Jonas J. Folk
13. Birthplace..... Springs Pa14. Maiden name..... Susan Shultz
15. Birthplace..... Somerset Co Pa16. Informant..... Harry Stahl
Address..... Grantsville Md17. Burial..... Grantsville
(Burial, cremation, or removal. Which?) Date thereof..... 12-12-1945
Cemetery or crematory..... Grantsville

Location..... Grantsville Md

18. Funeral director..... Mrs. M. Winterberg
Address..... Grantsville Md19. Date rec'd by registrar..... 1945
(Date rec'd by registrar) Ethel Rodriguez
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md County..... Garrett

City or town..... Rural Near Jennings Md
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH..... December 9 1945 at 10:30 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

and that I last saw her alive on Nov 1 1945 to Dec 9 1945.Immediate cause of death.....
old chronic Myocarditis

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

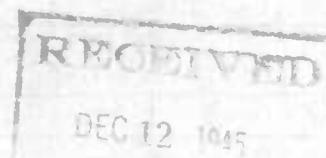
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or D.V.M.
Address..... Grantsville Md
Date signed..... Dec 11 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *BD*12366
166

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: *Garrett*
 County.....
 City or town..... *Oakland, Md.*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *60 years*
 Hospital, Institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... *Maryland* County..... *Garrett*
 City or town..... *Oakland* Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)

3. (a) FULL NAME
Owen Thomas Treacy.
 4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Married.*
 6. (b) Name of husband or wife *Mrs. Mary Sweeney Treacy*
 7. Birth date of deceased (m., day, yr.) *February 15th, 1873.* 8. (c) If alive, give age..... years
 8. AGE: Years *72* Months *9* Days *19* If less than one day
 hrs. min.
 9. Birthplace *Ireland.* (Town, county, and state)
 10. Usual occupation *Merchant.*
 11. Industry or business
 12. Name *James Treacy, Sr.*
 13. Birthplace *Ireland.*
 14. Maiden name *Bridget Boyle.*
 15. Birthplace *Ireland.*
 16. Informant *Mrs. Mary Treacy.*
 Address *Oakland, Md.*
 17. Burial Date thereof *December 7/45*
 (Burial, cremation, or removal. Which?) *St. Peter Cemetery.*
 Cemetery or crematory
 Location *Oakland, Maryland.*
 18. Funeral director *Energy D. Belding*
 Address *Oakland, Md.*
 19. Date rec'd by registrar *Dec 6 1945* *Julia Brown*
 (Date rec'd by registrar) *Registrar*

2. (a) If veteran, name war.....

3. (b) Social Security Number *none*

MEDICAL CERTIFICATION

20. DATE OF DEATH *December 4 1945* at *4:00 P.M.*
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Dec. 13-6* to *Dec. 4 1945* and that I last saw him alive on *Dec. 4 1945*

Immediate cause of death *Chronic Myocarditis* DURATION

Due to *anterior clavicle*

Due to

Other conditions *Prostate, by proctoscopy*

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *L. J. Bannister M.D.* M. D. or other
 Address *Oakland, Md.* Date signed *12/6/45*

RECEIVED FEDERAL BUREAU OF INVESTIGATION

1945 NO. 3712137002

RECEIVED
DEC 19 1945
BUREAU OF INVESTIGATION

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3A

CERTIFICATE OF DEATH

12367 166

Reg. Dist. No.

1. PLACE OF DEATH:

Garrett
County.....

Oakland, Maryland.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Harry Minrow Uphold.

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Widower

6.(b) Name of husband or wife..... Maud E. Lambert, Uphold.
Deceased

7. Birth date of deceased (mo., day, yr.) February 1st, 1882.

8. AGE: Years Months Days If less than one day

63 10 10 hrs. min.

9. Birthplace..... Maryland.
(Town, county, and state)

10. Usual occupation..... Miner

11. Industry or business

12. Name..... Clay Uphold.

13. Birthplace..... Maryland.

14. Maiden name..... Sarah McCabe.

15. Birthplace..... Maryland.

16. Informant..... Mrs. Beatrice Holler.

Address..... Oakland, Md.

17. Burial.....

(Burial, cremation, or removal. Which?)

Date thereof..... December 13/45
(month) (day) (year)

Cemetery or crematory..... Ashby Cemetery.

Location..... Crellin, Md.

18. Funeral director.....

Address..... Oakland, Md.

Dec 13 1945

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland, County..... Garrett

City or town..... Crellin, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

078-05-1120

MEDICAL CERTIFICATION

A.M.

20. DATE OF DEATH..... December 11th 1945, at 5:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 27, 1945, to December 11, 1945,

and that I last saw him alive on December 10, 1945.

Immediate cause of death..... Bronchitis pneumonia

DURATION

4 days

Due to..... Polypneumonia

Due to..... Lobar pleurisy.

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... Andrew J. Hayes M.D.

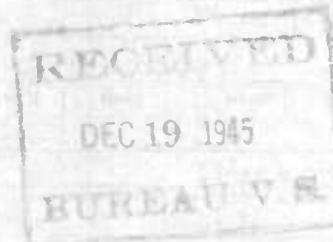
M. D. or other

101 Third Street

Oakland, Md.

12/13/45

Address..... Date signed.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Reg. Dist. No. 168

12368

1. PLACE OF DEATH:

County..... Garrett

City or town..... Finzel

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Christ Yommer

4. Sex

M	W	5. Color or race	6.(a) Single, married, widowed, or divorced
		Married	

6.(b) Name of husband or wife..... Susie Yommer

7. Birth date of deceased (mo., day, yr.) June 3-1881 6.(c) If alive, give age XX 56 years

8. AGE: Years Months Days If less than one day
64 6 - hrs. min.9. Birthplace..... Jennings Md
(Town, county, and state)

10. Usual occupation..... Lumber Sawer

11. Industry or business

MOTHER FATHER 12. Name..... George Yommer
13. Birthplace..... Germany

MOTHER 14. Maiden name..... Elizabeth Witzgall

15. Birthplace..... Germany

16. Informant..... Mrs Susie Yommer

Address..... Jennings Md

17. Burial..... Date thereof..... 12-6-1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Grantsville

Location..... Grantsville Md

18. Funeral director..... Alvin Winterberg

Address..... Grantsville Md

19. Date rec'd by registrar..... Dec 5 1945
Signature..... Madeline Michael

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md

County..... Garrett

City or town..... Jennings Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

3T3-18-2588

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH..... December 3rd., 1945, at 5.20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death.....

Coronary Occlusion

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... ---

Date of op.

Autopsy results..... no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE..... Prince H. Bowlin, M.D.

M. D. or other

Address..... Cumberland, Maryland

Date signed..... 12-3-45

Deputy Medical Examiner - Allegany Co.

